PRINTED: 06/05/2009

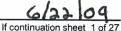
FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1): PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING **NVS641HOS** 05/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD **DESERT SPRINGS HOSPITAL** LAS VEGAS, NV 89119 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 Initial Comments S 000 This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on 04/30/09 and 05/01/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The following nine complaints were investigated. Complaint # 21697 - Unsubstantiated Complaint # 21003 - Unsubstantiated Complaint # 21727 - Unsubstantiated Complaint # 21745 - Unsubstantiated Complaint # 18051 - Substantiated (Tag # S0143, S0322) Complaint # 21515 - Substantiated (Tag # S0297, S0298) Complaint # 18985 - Substantiated (Tag # S0310) Complaint # 21612 - Substantiated (Tag # S0335) Complaint # 21277 - Substantiated without deficiencies The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations. actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified. S 143 NAC 449.332 Discharge Planning S 143

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(X6) DATE

M5KS11





(a) Have a process for discharge planning that

(b) Develop and carry out policies and

SS=D

1. A hospital shall:

applies to all inpatients; and

PRINTED: 06/05/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVS641HOS 05/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD **DESERT SPRINGS HOSPITAL** LAS VEGAS, NV 89119 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 143 Continued From page 1 S 143 Tag S 143 procedures regarding the process for discharge planning. The identified patient had been discharged prior to the survey and it This Regulation is not met as evidenced by: Based on interview, record review and document is not possible to address this review the facility failed to carry out policies and particular patient. procedures to ensure the safe discharge of a All patients admitted to the facility patient. (Patient #3) have the potential to be affected by Finding Include: this practice. On 04/21/08 a report from the Division of Aging The facility policy "Nurses Discharge Services indicated Patient #3 was discharged Notes and Instructions" was from the facility on 04/18/08, with a Foley catheter reviewed, no revisions were required. in place and no physician discharge instructions for Foley catheter care or home health care. The The Director/Manager of the unit patient was discharged home by ambulance with involved with this individual patient no clothing or belongings and wrapped only in a has reviewed the policies and blanket. procedures related to discharge planning with her clinical staff. The A Discharge Summary dated 05/07/08, indicated Unit Director has also discussed with the patient was a 94 year old female who was her staff the need for documentation admitted to the hospital on 04/17/08 because of of discharge instructions, discharge acute GI (gastrointestinal) bleed with blood loss assessment, and medication and anemia. The patient was transfused with 2 reconciliation. Additionally, all units of blood and had an EGD clinical Directors/Managers have (esophagogastroduodenoscopy) procedure which reviewed these policies and revealed multiple gastric ulcers. The patient was procedures with their staff. No placed on a protein pump drip post procedure. individual counseling was completed The patient was hemodynamically stable and was as the employee involved in this discharged on 04/18/08, with Protonix medication patient's care is no longer employed to take twice a day. at the facility.

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The Emergency Room Nursing record dated 04/17/08, indicated the patient was brought to the

patient was triaged in the emergency room at

was disrobed a 6:45 AM and placed in a gown.

6:37 AM. The patient had a Foley catheter inserted on 04/17/08 at 10:45 AM. The patient

emergency room by ambulance from home. The

Individual responsible:

Units

Directors/Managers of Nursing

Date of Completion: 6/30/09

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE S COMPL	
		NVS641HOS		B. WING _		05/0	01/2009
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
DESERT	SPRINGS HOSPITAL	•		T FLAMING AS, NV 891			
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S 143	Continued From pa	ge 2		S 143			
	A Nursing Admission Assessment dated 04/17/08, documented under Genitourinary the patient had a Foley catheter in place.						
	dated 04/18/08, ind catheter, IV (intrave anticipated discharg occupational therap (certified nursing as patient would be fol A facility Exit Care	int Initial Assessment icated the patient has enous line) and oxygoge plan included horoy, physical therapy assistant). A note indicated by a case man patient Information for the indicated the indicated by a case man patient information for the indicated	d a Foley en. The ne health, and CNA cated the nager.				
(   i	04/18/08 at 7:30 PM, revealed the only discharge instruction documented on the form was for the patient to follow-up with her primary care physician in 1 week.						
	A Physician Progress Note dated 04/18/08, indicated the patient was seen and the hemoglobin and hematocrit were stable. "The patient was stable for discharge home today."						
	A Physicians Order the following:	A Physicians Order dated 04/18/08, documented the following:					
	"D/C (discharge) today."     "Appointment with primary care physician in one week."     "Patient needs transport home, inform Case Manager."						
		ed 04/18/08 at 7:30 F t was discharged ho retcher.					
÷	record indicated the the nursing notes th	AM, a review of the ere was no document at the patients Foley y nursing staff prior t	tation in catheter				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDII B. WING	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED - 05/01/2009	
NAME OF C	PROVIDER OR SUPPLIER		STREET AD	DDESS CITY	STATE, ZIP CODE		1/2009
NAME OF F	NOVIDER OR SUPPLIER						
DESERT	SPRINGS HOSPITAL			T FLAMING AS, NV 891			
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S 143	patients discharge. of a physicians order discharged home where the patients of the patients o	There was no docurer for the patient to be with a Foley catheter in DAM, the Performanger reviewed Patient confirmed there was use that nursing staff tients Foley catheter formance Improvements and conduct a final catent prior to discharge Notes and Irrindicated under Processional include:  Scharge Notes and Irrindicated under Processional Irrindicated under Proce	e in place.  ce t #3's so no prior to ent llow nal arge and entuction bedure:  on.  hysician activity structed to e patient ons by es ecking ent on entuction on the patient on the patien	S 143			
	Severity: 2 Sco	pe: 1				•	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

05/01/2009

## Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE C	ONSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVS641HOS

B. WING \_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE

### DESERT SPRINGS LIGSRITAL

NAME OF PROVIDER OR SUPPLIER

2075 EAST FLAMINGO ROAD

DESERT	SPRINGS HOSPITAL		S VEGAS, NV 89119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 143	Continued From page 4		S 143			
	Complaint #NV00018051					
S 297 SS=G	NAC 449.361 Nursing Service		S 297	Tag S 297		
	8. The chief administrative nurse shall dipolicies, procedures and standards relative provision of nursing services and shall est that the members of the nursing staff cat those policies, procedures and standards must documented and accessible to each meethe nursing staff in written or electronic for chief administrative nurse must approve element of the policies, procedures and standards before the element may be us into effect.  This Regulation is not met as evidenced Based on interview, record review and direview the chief nurse failed to ensure nestaff carried out policies and procedures concerning the use of alcohol prep solutifire response policies. (Patient #4)  Finding include:  A facility Physician Transfer Summary day 03/21/09, indicated Patient #4 was a 90 of female admitted to the facility with diagnosincluding symptomatic bradycardia (low frate) hypertension and dementia. The pataken to the cardiac catheterization lab to pacemaker implantation. The pacemake implantation was complicated by an intraoperative fire in the cath lab. The pasuffered significant facial and neck burns was transferred to another Hospital's Interest.	ing to the insure rry out is. The is. The is to be insure of orm. The each is ed or put is downward occument ursing it ions and insured it ions and		The identified patient had been transferred to another facility prior to the survey and it is not possible to address this individual patient.  All patients admitted to the facility have the potential to be affected by this practice.  The Chief Nurse Officer reviews and authorizes all policies, procedures and standards of care related to nursing care. The facility has access for all staff to the policies, procedures, and standards via the Valley Health System Internet website, with all staff having ready access to computers. Prior to the initiation of Intranet access to policies and procedures in 2008, staff was educated on the procedure for accessing this information. The facility has reeducated the clinical staff in the Cardiac Cath Lab related to the procedure for accessing the "Red Book" (Policy and Procedure).		

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STATE FORM

							: 06/05/2009
Bureau	of Health Care Quali	ty & Compliance				FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/01/2009	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
DESERT	SPRINGS HOSPITAL	-		T FLAMING AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
S 297	On 04/30/09 at 9:00 indicated on 03/22/Patient #4 was in the lab for placement on The Chief Nurse incompassed prep was used allowed to dry for 20 procedure started. Oxygen re-breather activated the Bovie was witnessed by the and the patients draffire. The cardiologis The fire was extinging bulb syringe with staffire and a wet towel second and third dechest, left shoulder room physician was scene and assessed cleaned the patients transported to anoth Chief Nurse did not was notified. The in State Health Division Sentinel Event reposubmitted to the Nethe facility on 04/07. Nurse indicated the non alcohol preps a prevention procedus olution to pool und the patient until the	age 5 D AM, the Chief Nurs O9 at approximately the cardiac catheteriza of a permanent pacendicated a Chlora Pre- dicated and mask. When the sur- mands and staff appe expanded and cast removed the patient suished by the tech the dicated and responded the patients airway and back. The emer- dicated and responded the patients airway as burns. The patient for called and responded the patients airway as burns. The patient for a called and responded on on 03/26/09 at 11: for was completed an avada State Health D for at 12:30 PM. The facility was looking a find revising the fire ri fre to include not allow for the patient and no prep solution has dri did the facility's investi-	7:00 PM, ation suite maker. p alcohol kin and to the high flow reconnect that present aught on his drape. Lat used a hish the led eck, face, reconnect to the lat using a livision by the Chief at using lisk wing preport draping led. The	S 297	All staff, including Cath Lab personnel are required to cor annual competencies, with the annual competency complete 2008 and due to be complete 2008 and due to be compete include:  1. Infection Control 2. Handling Hazardou Materials 3. Electrical and Medin Device Safety 4. National Patient Sandous Goals 5. Bloodbourne Pathon 6. Emergency Prepare 7. Understanding Tuberculosis 8. Understanding HIP, 9. Healthcare Facility Security 10. Fire Safety 11. Body Mechanics  The Director of the Operating and Directors/Managers of the Invasive Procedures units has reviewed and revised facility and procedures for prepping patients and Surgical Skin Antisepsis to ensure that the practice meets the current AC standards and those of current evidence based standards of	ne last ed in ed by encies s cal fety gens edness AA	
		ed the facility's investi e three factors that c			All clinical staff are required to	0	

1. The patient was on high flow oxygen with a

re-breather mask. There was no oxygen tank in the cath lab. All oxygen was dispensed from an

to the incident.

Resources file.

demonstrate current competency on

these policies and procedures, this documentation is on file in Human

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Bureau	of Health Care Quali	ty & Compliance				FURM /	APPROVEI
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	:R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/01/2009	
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S 297	oxygen wall outlet.  2. The facility used alcohol based preprecommended dryinstaff allowed the preprior to starting the staff allowed procedure and residence and residence and residence and residence and staff allowed the staff allowed the staff allowed the procedure and the pro	Chlora Prep which wand highly flammable time was 3 minuted procedure.  under the patient to were not removed pridual alcohol based Conthe Chux pad may lead a contributing factor activated a cauted drape covering the p	e. The es. The minutes  catch any or to the chlora have ctor to the ery tool atient  indicated alora Prep e. x pad was ulder area alution to ed a 26 ne ecall how oped onto ux pad following he mask on drape	S 297	The facility reviewed the policy procedure for fire response, no revisions required in policy. Ca Lab staff were re-educated on t fire response policy which included calling a "Code Red".  All employees are responsible for knowledge of facility policies amprocedures and ensuring that the is consistent with those evidence based standards of care for high flow oxide a non-rebreather mask. The nurse inverted the oxygen mask the oxygen bag out of the sterile practice does not follow standards of care for high flow or hospital standards, or the manufinstructions for use of the mask. counseling of staff was completed to placement of oxygen mask.  The Director of Pulmonary Service with clinical staff reviewed with the staff the proper procedures for Office Therapy in the Cardiac Cath Lab The root causes identified for this include:  1. Concerns with proper furof equipment and oxygen system.	th he des or d leir practice re. lygen procedure to keep field. This xygen, facturer's Individual ed related lxygen lxygen s incident lxygen ces incident	

was placed on the patient which covered her

fashion. Employee #1 indicated the prep had

dried for 15 to 20 minutes prior to the start of the

procedure. Employee #1 left the cath lab and was

face, oxygen mask and head in a tent like

not present when the procedure started. Employee #1 heard the patient scream and

STATE FORM

2. Orientation and training in the

fires in these cases.

Invasive Procedure areas did not

address how to assess patients for

a high risk of fire, or how to prevent

							: 06/05/2009	
Bureau	of Health Care Quali	ty & Compliance				FORM	APPROVED	
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DESERT	SPRINGS HOSPITAL			ST FLAMING AS, NV 891				
			LAS VEG	MO, NV 091	19			
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S 297	Continued From pa	ge 7		S 297				
	surgeon pulling off to on fire. When employed with two blankets shamoldering and the The surgical technic sterile water on the towel to put out the acknowledged no of (fire alarm). Employ member called the findicated the facility under the patients provided them when the control of the surgical states of the facility of the patients of the facility now used a very removed them when the surgical states of the s	ne called a 6666 cooree #1 did not know if fire department. Emp no longer placed Clorior to using Chlora washcloth or towel are the prep was comp	hich was cath lab chest in the floor. well of sterile wet de red if any staff ployee #1 nux pad Prep. The nd pleted.		The facility reported this incident the State of Nevada Sentinel Evand to the Joint Commission. Tommission conducted a specific on May 28, 2009 and deemed the Root Cause Analysis had been and credible and that the associplan was appropriate and acception in the Individual responsible:  Director of Surgical Services, Chief Nursing Officer, Director Ancillary Services, Director of Pulmonary Services, Risk	vent site The Joint al survey hat the thorough iated action otable.	The contraction of the state of	
		PM, Employee #2 in ent of a permanent p		Manager Daufannana				
		Chux pad was place			Improvement Manager			
the patients head and shoul was used to prep the patien patient was receiving 10 lite		nd shoulders and Ch e patient's chest are g 10 liters of oxygen	llora Prep a. The via a non	Date of Completion: 5/15/09				
	patient and the patient's prep on the patient's #2 indicated she say tool on the patients	he fire was extinguis	after the mployee autery rape The ient's hed by		This employee's statement is false. Employee # 2 received orientation upon hire of hospital policies and procedures, includin fire safety and also completes competencies annually with the			

water to douse the flames. Employee #2

indicated she did not follow the facility's fire

response plan and call a code red when the fire occurred. Employee #2 confirmed the fire department did not show up at the facility or conduct an investigation into the cause of the fire. Employee #2 indicated she had been working in the cath lab for 7 years as a scrub monitor and circulating nurse but had not been trained by the

most recent completion in 2008.

Those competencies include fire

safety, see page 12).

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Bureau of Health Care Qu	ality & Compliance				FORM	APPROVED
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potential risk of ficausing injury to  A facility Incident documented the  "During the disse permanent pacer cautery for hemo patient's head an surgeon immediatechnician douse solution on fire an extinguish fire. Eto assess patient compromised. Facutive Officer transferred to how.  The Sentinel Ever 04/07/09 at 12:30 Factors indicated "The incident was performance/admincluded equipment procedure review analysis and staff. Chlora Prep drugingredients consi	e of alcohol based preparammable vapors igniting a patient.  Report dated 03/22/09 following:  ection of a pocket to plamaker battery, the surgistasis. A fire ensued ald neck. Fire was put or ately removing drapes, difire with 800 cc steriled also used a bulb symmergency room physicists airway which was not amily informed by CEO and visited patient. Propital burn ward."	ice a leon used bout the le saline linge to lian called lian ted contributing live action review, tion J."	S 297	Tag S 297 All employees in Invasive Procedure areas received reviewed "Important Inform on Fire Safety with a signerattestation of their underst of the principles of fire safe the fire risk assessment.  Individuals responsible: Director of Surgical Serve Director of Ancillary Serve Risk Manager, Performal Improvement Manager  Date of Completion: Ap 2009  A. Development and imple of fire risk screening too be based on AORN star UHS Corporate develop risk screening tool for al facilities.  1. Electronic document fire risk assessment Cardiac Cath Lab for the MAC Lab  2. Implemented use of tool used by other V facilities for fire risk assessment in those that don't have elect	mation ed canding ety and vices, vices, nce oril 15, mentation ol, tool to ndards. oed a fire il UHS tation of t in ormatted in paper THS e areas	

Warnings Included:

"For external use only. Flammable, keep away from fire or flame. To reduce risks of fire:

a. "Solution contains alcohol and gives off

documentation.

June.

3. Corporate UHS developed a

assessment that was implemented in first week of

corporate-wide tool for risk

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Bureau	<u>of Health Care Quali</u>	ty & Compliance	***			FURIVI	APPROVED
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S 297	flammable vapors." b. "Do not drape or laser) until solution of 3 minutes on hair c." Avoid getting solumny take much long d." Do not allow solue. "Remove wet mate Directions:  1. "To reduce the ristrategies are recorda." The end of the the solution which is prep area." b. "Use in a well vere." "Tuck prep towels remove." d. "Remove wet mate." "Drape after solution." The facility's Surgical Washing/Painting pos/06 included the foundation of the patient and away patient electrode and burns may result if a with the skin."  2. "Sufficient time for flammable antimicrobefore electrosurgical control of the proposition of the patient ship."	use ignition source (dis completely dry" (mriess skin) ution into hairy areas ger to dry completely ition to pool." rerials from prep areas sk of fire the following mended:" prep, discard any per not required to cover itilated area." sto absorb solution, terial from prep areastion is completely dry all Skin Prepolicy and procedure collowing: button from pooling lay from the electrosured tourniquets. Chemical allowed to remain in the complete evaporate obtains agent needs to all devices or lasers anable antimicrobial agent	s. Solution  c. Solution  c. "  g  ortion of er the  then  then  c. "  dated  beneath cgical ical contact  ion of a occur are used.	S 297	B. Educated all OR, Cath La Special Procedures, and staff regarding fire risk assessment.  1. Education packet 2. AORN Guidance Statement, Fire Previnthe Operating Rocal Surgical Prime Patient is on Fatient is on	vention om er, "The Fire"!  ou can es"  es, ee  s0, 2009  ve  e risk tions trisk alidate eting	

"Open towel and pat dry the area dry to remove excess scrub solution. Remove the towels used

risk assessment. 3. ECRI Guidance Article-

"Conducting a Safety Audit"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MUL <sup>-</sup> A. BUILDI	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		1/2009
DESERT	SPRINGS HOSPITAL	•	2075 EAS	ST FLAMING AS, NV 891	GO ROAD		
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S 297	Continued From parto square off the fiewhile paying close atowel across preper The facility's AORN Operative Registers Policy last revised 1. "When an alcohol minimum amount or sufficient time for furth draping."  2. "Observe drying time to drape patient undry."  3. "Do not allow pool including under patient time for furth drape patient undry."  4. "Remove bowls of field as soon as positive facility's Fire Research and the facility's Fire Research across the facility's Fire Research across property and the facility's Fire Research across preperty and the facility is Fire Research across preperty and the facility's Fire Research across preperty and the facility is Fire Research across preperty and the facility is fire facility's Fire Research across preperty and the facility is fire facility is fire facility is fire facility is fire facility in the facility is fire facility."	ge 10  Id by lifting edges of attention not to drag ed field."  (Association of Period Nurses) Fire Safe /05 included the followater of the solution and allowater of the solution from the solution from the solution from the solution of the solution of the specific location of the solution of the sol	the towel edges of ty Tool Kit owing: sed, use ow fore utes) do s fully tion."( m sterile vised 2-6666 f the fire, also	S 297	Individuals responsible Director of Surgical Se Director of Ancillary Se Risk Manager, Perform Improvement Manager  Date of Completion: Au Ensure Chloraprep soluti according to manufacture guidelines.  New process for preppin Cardiac Cath Lab:  1. Chux will be rem patient is preppe 2. Sterile towels wil adjacent to patie prep to catch pre removed after pre draping. 3. 3 soaked sterile at back of surgice be used to exting 4. Basin of sterile we on back of surgice to be used to ext 5. Prep time and 3 prompt added to throughout the V System.	e: ervices, ervices, ervices, eance  agust 30, 2009  ion used er's  g in the enoved after ed. Il be placed ent in area of ep run off and ep and prior to towels to be kept al scrub table, to guish any fire vater to be kept cal scrub table, inguish any fire minute timer MAC lab	t
	them of an alarm ac Severity: 3 Sco	tivation. pe: 1	it to notiny		Review of prep s     be completed wit     assistance of Infe     Control practition	th ection	
S 298 SS=G	Complaint #NV0002 NAC 449.361 Nursir			S 298	Individuals responsible: Director of Surgical Servi Infection Control Coordin	ices, nator	
	9. A hospital shall er proper treatment and				Date of Completion: June	30, 2009	

		. <b>J</b>			**************************************		: 06/05/2009
Bureau	of Health Care Quali	ty & Compliance				FORM A	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	CLIA (X2) MULTIPLE CONSTRUCTION ER: A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	11100-11100	STREET AD	DRESS CITY	STATE, ZIP CODE	<u>  05/0</u> 1	1/2009
	SPRINGS HOSPITAL	•	2075 EAS	ST FLAMING AS, NV 891	GO ROAD		
(X4) ID PREFIX TAG	EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES  ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		OULD BE	(X5) COMPLETE DATE		
S 298	services in accorda standards of practic This Regulation is a Based on interview, review the facility fa received proper trea service in accordan- standards of practic Finding include:	nce with nationally rece and physicians' or not met as evidence record review and diled to ensure a patie atment and care by it ce with nationally rece. (Patient #4)  Transfer Summary dece (Patient #4)	d by: locument ent ts nursing cognized  ated year old loses heart atient was to have a er atient s and hsive  e 7:00 PM, ation suite haker. to alcohol in and	S 298	Tag S 298 The identified patient had been transferred to another facility puthe survey and it is not possible address this individual patient.  All patients admitted to the fact have the potential to be affected this practice.  The Chief Nurse Officer review authorizes all policies, procedus standards of care related to not the facility also has a dedicate Procedure committee comprismultidisciplinary group and whomeomorphic include Clinical N Specialists who drive the evide practice and current national scare based on research of been all employees are responsible knowledge of facility policies a procedures and ensuring that is consistent with those evider standards of care.  Individuals responsible: Chief Nursing Officer, Direct Surgical Services, Risk Mar Performance Improvement Manager	rior to e to  ility ed by  vs and ures and ursing care, d Policy and ed of a lose lurse ence based standards of st practice. for and their practice ace based	

procedure started. The patient was on high flow oxygen re-breather mask. When the surgeon

activated the Bovie Knife there was an arch that was witnessed by the surgeon and staff present and the patients drape expanded and caught on fire. The cardiologist removed the patients drape. The fire was extinguished by the tech that used a

Date of Completion: June 30, 2009

PRINTED: 06/05/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN		(X3) DATE S COMPL		
		NVS641HOS		B. WING		05/0	01/2009	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, 5	STATE, ZIP CODE			
DESERT	SPRINGS HOSPITAL	-		AST FLAMINGO ROAD GAS, NV 89119				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
S 298	Continued From particles bulb syringe with strine and a wet towel second and third dechest, left shoulder room physician was scene and assesse cleaned the patient transported to anothe Chief Nurse did not was notified. The in State Health Division Sentinel Event repossibility on 04/07 Nurse indicated the non alcohol prepara prevention procedu solution to pool und the patient until the Chief Nurse reported indicated there were to the incident.  1. The patient was re-breather mask. The cath lab. All oxyoxygen wall outlet.  2. The facility used alcohol based preprecommended drying staff allowed the proprior to starting the second and splace.	terile water to extingual. The patient sustainegree burns on her not and back. The emers called and responded the patients airway its burns. The patient ther facility's burn unit trecall if the fire depanded on on 03/26/09 at 11: ort was completed an evada State Health D7/09 at 12:30 PM. The facility was looking a and revising the fire riure to include not allowed the patient and not prep solution has dried the facility's investive three factors that complete the patient and not prep solution has dried the facility's investive three factors that complete was no oxygen yield was dispensed for the patient and not prep solution has dried the facility's investive three factors that complete was no oxygen was dispensed for the patient and not prep which we have a dispensed for the patient and not prep which we have a dispensed for the patient and not prep which we have a dispensed for the patient and not prep which we have a dispensed for the patient and not prep which we have a dispensed for the patient and not prep which we have a dispensed for the patient and not prepare which we have a dispensed for the patient and not prepare which we have a dispensed for the patient and not prepare which we have a dispensed for the patient and not prepare which we have a dispensed for the patient and the	uish the led leck, face, regency led to the y and was then to the lartment to the lartment to the livision by e Chief at using lied. The ligation contributed with a lart tank in from an les. The les. The lartment les lartm	S 298				
	the procedure and r Prep still present or been a fuel source	rep were not removed residual alcohol base n the Chux pads may and a contributing fad geon activated a caute	ed Chlora have ctor to the					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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M5KS11

If continuation sheet 13 of 27

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05/01/2009

Bureau of Health Care Quality & Compliance

STATEMENT	OF	DEFICIENCIES
CIVICINICIAI	91	DELICITIACIES
AND PLAN OF	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	CONSTRUCTION	
A. BUILDING		
B. WING		

(X3) DATE SURVEY COMPLETED

NVS641HOS

STREET ADDRESS, CITY, STATE, ZIP CODE

#### **DESERT SPRINGS HOSPITAL**

NAME OF PROVIDER OR SUPPLIER

2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

			GAS, NV 89119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 298	Continued From page 13		S 298			
	for hemostasis the drape covering the p ignited burning the patient.	atient				
	On 04/30/09 at 11:00 AM, Employee #1 she was responsible for applying the Chroto the patient prior to the placement of a permanent pacemaker battery procedur Employee #1 indicated a thick blue Churwas placed under the patients head and area prior to the administration of the prosolution to the patient's chest. Employee indicated a 26 ml (milliliter) Chlora prepon the patients chest. Employee #1 coul recall how much of the prepolution madripped onto the Chux pads under the patient following the administration of the solution. The patient had a non re-breatl oxygen mask on and oxygen was flowing mask. A drape was placed on the patient covered her face, oxygen mask and head tent like fashion. Employee #1 indicated had dried for 15 to 20 minutes prior to the the procedure. Employee #1 left the catter was not present when the procedure state Employee #1 heard the patients drape whon fire. When employee #1 entered the with two blankets she saw the patients of smoldering and the drape was on fire on The surgical technician had thrown a bosterile water on the patient and used a stowel to put out the fire. Employee #1 acknowledged no one called a 6666 cod (fire alarm). Employee #1 did not know it member called the fire department. Empindicated the facility no longer places children in the patient and used a stowel to patient the fire department. Empindicated the facility no longer places children in the patient and used a stowel to put out the fire department. Empindicated the facility no longer places children in the patient and used a stowel to put out the fire department. Empindicated the facility no longer places children in the patient and used a stowel to put out the fire department. Empindicated the facility no longer places children in the patient and used a stowel to put out the fire department. Empindicated the facility no longer places children in the patient and used a stowel to put out the fire department.	lora Prep e. x pads shoulder ep e #1 was used d not y have atient. nder the e prep hable g to the pt which id in a the prep le start of n lab and wred. and saw the nich was cath lab hest the floor. wel of terile wet le red f any staff ployee #1 ucks				
deficiencie	under the patients prior to using Chlora I facility now uses a washcloth or towel ar are cited, an approved plan of correction must be	ıd				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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M5KS11

If continuation sheet 14 of 27



05/01/2009

Bureau of Health Care Quality & Compliance

STATEMENT	OF DEFICIENCIES
AND PLAN O	F CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	OOM LETED
B. WING	

NVS641HOS

STREET ADDRESS, CITY, STATE, ZIP CODE

DESERT			075 EAST FLAMINGO ROAD AS VEGAS, NV 89119				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
S 298	Continued From page 14		S 298				
	removes them when the prep is comple	ted.					
f deficiencie	on 04/30/09 at 1:00 PM, Employee #2 in prior to the placement of a permanent be battery procedure a Chux pad was placed the patients head and shoulders and Chawas used to prep the patient's chest are patient was receiving 10 liters of oxygen rebreathe mask. The Chux pad was left patient and the patient was then draped prep on the patient's chest had dried. En #2 indicated she saw the surgeon use of tool on the patients chest and saw the discovering the patients head catch on fire surgeon removed the drape and the patients was on fire. The fire was extinguist the surgical technician who used a basin water to douse the flames. Employee #2 indicated she did not follow the facility's response plan and call a code red when occurred. Employee #2 confirmed the fire department did not show up at the facility conduct an investigation into the cause of Employee #2 indicated she had been were the cath lab for 7 years as a scrub monit circulating nurse but had not been trained facility on the use of alcohol based prepapetential risk of flammable vapors igniting causing injury to a patient.  The Sentinel Even Report- Section II dae 04/07/09 at 12:30 PM, under Primary Confection included equipment modification. The correct included equipment modification, policy procedure review, process review, situational analysis and staff education and training are cited, an approved plan of correction must be are cited, an approved plan of correction must be	acemaker ed under elora Prep a. The via a non under the after the mployee autery rape The ient's shed by n of sterile re y or of the fire re ry or of the fire or the and ed by the s or the ng and ted ontributing	in 10 days after	er receipt of this statement of deficiencies			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.





Bureau	of Health Care Quali	ty & Compliance				FORM	1 APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN		(X3) DATE S COMPL	
		NVS641HOS		B. WING_		05/0	01/2009
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
DESERT	SPRINGS HOSPITAL	-		ST FLAMING AS, NV 891	· · · · · ·		
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S 298	Continued From pa	ige 15		S 298			
	ingredients consiste 2% (Antiseptic) and (Antiseptic)	acts indicated the act ed of Chlorhexidine ( I Isopropyl Alcohol 70	Gluconate				
	Warnings Included:	'					
	from fire or flame. T a. "Solution contain: flammable vapors." b. "Do not drape or u laser) until solution (minimum of 3 minu c."Avoid getting solu may take much long d."Do not allow solu	use ignition source (discompletely dry" utes on hairless skin) ution into hairy areas ger to dry completely	e: off cautery, ) s. Solution /."				
	Directions:						
	strategies are recon a. "At the end of the the solution which is prep area." b. "Use in a well ver c. "Tuck prep towels remove." d. "Remove wet ma	e prep, discard any pos s not required to cove	ortion of er the then				
	The facility's Surgica Washing/Painting po 08/06 included the fo	olicy and procedure	dated				-

1. "Keep the prep solution from pooling beneath the patient and away from the electrosurgical patient electrode and tourniquets. Chemical

burns may result if allowed to remain in contact





					<b>.</b>		): U6/U5/20U5
Bureau	of Health Care Quali	ty & Compliance				FORM	I APPROVED
	IT OF DEFICIENCIES OF CORRECTION	IES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT A. BUILDIN B. WING		(X3) DATE S COMPL	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		3172.003
DESERT	SPRINGS HOSPITAL	-	2075 EAS	T FLAMING AS, NV 891	O ROAD		
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S 298	Continued From pa	ge 16		S 298			
	with the skin."						
	flammable antimicrobefore electrosurgic Evaporation of flam decreases the poss "Open towel and pa excess scrub solution Remove the towels lifting edges of the tattention not to drag prepped field."  The facility's AORN Operative Registere Policy last revised 1  1. "When an alcohol minimum amount of sufficient time for fudraping."  2. "Observe drying tinot drape patient undry."  3. "Do not allow pool including under patient patient time for fudraping."	at dry the area dry to on. used to square off the cowel while paying cloped gedges of towel across (Association of Period Nurses) Fire Safe /05 included the following fithe solution and allowes to dissipate before (minimum 3 minimum 1 minimum 2 minimum 3 m	occur are used. agents  remove ne field by ose oss  ty Tool Kit owing: ed, use ow ore utes) do fully ion." (				

STATE FORM

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S 310 NAC 449.3624 Assessment of Patient

1. To provide a patient with the appropriate care at the time that the care is needed, the needs of

S 310

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If continuation sheet 17 of 27



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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN		(X3) DATE SU COMPLE		
	<u> </u>	NVS641HOS		B. WING _		05/01	1/2009	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE	4014	12000	
DESERT	SPRINGS HOSPITAL	-	2075 EAS	T FLAMINGO ROAD AS, NV 89119				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
. S 310	the patient must be qualified hospital per patient's contact with assessment must be accurate as related. This Regulation is Based on interview, review the facility far appropriate care an patients condition the with the hospital. (Perindings include:  A History and Physisthe Patient #6 was at to the facility on 07/malignant hypertensions obstructive pulmona aorto-birenal and acsurgery. The patient of both legs post surgery. The patient of both legs post surgery. The Patient Care As 07/07/08 at 8:00 Phintegumentary systems at the patient developed ulcer.  The Patient Care As Pressure Ulcer record the patient developed ulcer.  The Patient Care As Pressure Ulcer record the patient developed ulcer.	e assessed continually ersonnel throughout to the hospital. The pe comprehensive and to the condition of the not met as evidenced, record review and dealed to provide a patient de continually assess hroughout the patient Patient # 6)  ical dated 07/28/08, if a 75 year old female (07/08, with a diagnosision secondary to billy and severe chronicary disease. The patient ortofemoral bypass got had weakness and	the and and patient.  Indicated indi	S 310	Tag S 310  The identified patient had been discharged prior to the survey a is not possible to address this particular patient.  All patients admitted to the faci have the potential to be affecte this practice.  The Director/Manager of the uninvolved with this individual patihas reviewed the policies and procedures related to admission assessment and documentation that assessment and the ongoin assessment that is to be compliand documented every twelve had approved Skin Care Protocol. Tacility conducts a wound and Scare Nurse specialist and a ME approved Skin Care Protocol. Tacility conducts a wound and sincidence and prevalence study study completed in January 200 showed the rate of incidence as The Director/Managers of the uninvolved with the care of this individual patient have reviewed policies and procedures with the clinical staff. Individual staff we also counseled following a medirecord review. The facility has a formed a RISC (Resource In Sk Care) team to act as resources a clinical staff when caring for a pawith a decubitus,	and it  ility d by  nit ient n of ng eted hours. kin EC The kin t, the 09 s 2%. nits d the eir re ical also in for		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.





				·		: 06/05/2009
Bureau of Health Care Quali	ty & Compliance		·		FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/01/2009	
NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS CITY	STATE, ZIP CODE	1 00/0	11/2009
DESERT SPRINGS HOSPITAL	•	2075 EAS	ST FLAMING AS, NV 891	O ROAD		
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record was reviewe Improvement. The I facility's policy to initial patients who had a ulcers or who prese breakdown. The wookeeping the patients managing incontine every 2 hours, apply needed, and the use heels and elbows. Was no documented protocol in the patien Director acknowledge the nurses initiated documented the condecubitus ulcer on a A Rehabilitation Hose Physical dated 07/2 prolonged bedrest a developed a sacral was consulted for even Ulcer: The patient he sacral wound that we tissue. The wound was a large stage 2 decubitus under the sacral was a large stage 2 decubitus un	DPM, Patient #6's med with the Director of Director confirmed it tiate a wound care protected to the facility wound care protocol in skin clean and dry, ence, repositioning the ying moisturizing cree of protective device. The Director confirmed evidence of a wourd care protocol a wound care protocol dition of the patient.	f Quality was the rotocol on decubitus ith skin cluded e patient am when es for ed there ed care The dication col or s sacral tory and co ent und care cubitus entimeter) otic e wound unding the vell as and raw	S 310	Individuals responsible: Director/Manager of Medical/Surgical Units, Director/Manager of Critical Wound Care Coordinator Date of Completion: June 30		

wound had a moderate amount of drainage.

The facility's Skin Assessment and Pressure Ulcer Wound Care Protocol indicated the facility used the Braden Scale for predicting pressure sore risk. The Braden Scale consisted of the

following categories:

STATE FORM





PRINTED: 06/05/2009 FORM APPROVED

# Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CO	INSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVS641HOS

B. WING

05/01/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER S		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
			T FLAMING AS, NV 891		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	:ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 310	Continued From page 19		S 310		
	<ol> <li>Sensory Perception</li> <li>Moisture</li> <li>Activity</li> <li>mobility</li> <li>Nutrition</li> <li>Friction and Shear.</li> <li>The nurses were to complete the Braden Score daily during daylight skin assessme identify high risk patients for pressure ulcuryon identification of a pressure ulcers newere to initiate the Pressure Ulcer Monitor Tool which included the following:</li> <li>Stage I: Non-blanchable redness of intact</li> <li>"Provide pressure relief by repositioning one to two hours. Use pressure relieving such as, pressure reduction boots, bed wand/or pillows."</li> <li>"Protect the skin from incontinence throuse of moisturizing cream. Apply frequent after each episode of incontinence."</li> <li>"Document the skin assessment every</li> <li>Stage II: Partial thickness skin loss involve pidermis or dermis, or both.</li> <li>"Obtain consent for photo of wound usi block. Document the patients name, date time on the photo."</li> <li>"Measure and document the size in centimeters and appearance of wound be surrounding tissue."</li> <li>"Clean with Normal Saline. Apply No-Si</li> </ol>	ent and ers. eurses oring  t skin. g every devices, edges, ough the tly and shift." ing ing light and			
	are cited, an approved plan of correction must be re				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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If continuation sheet 20 of 27





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Bureau d	of Health Care Quali	ty & Compliance				FORIV	IAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS641HOS			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		SURVEY ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		7112000
DESERT	SPRINGS HOSPITAL	-		T FLAMING AS, NV 891			
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S 310	Continued From pa	ige 20		S 310			
,	-	rrounding intact skin.	."				
	<ul> <li>4. "Apply Duoderm thin (hydrocolloid), label and date and change every 3 days." If draining, apply Allevyn foam adhesive or Allevyn foam, window paned with hypafix tape. Date dressing and change every 3 days. measure and document with each dressing change."</li> <li>5. "Reposition every 2 hours."</li> <li>The facility's Pressure Ulcer care Policy dated 06/08, included the following:</li> <li>1. "Institute the Pressure Ulcer Wound Care Protocol on all patients who have been identified as having a pressure ulcer."</li> </ul>						
	2. "Obtain and initiate standing pressure ulcer wound care orders for a stage II or greater pressure ulcer."						
•	3 "The wound and skin nurse is available for skin care consultation and may be called by any member of the team after a physician's order has been received."						
On 05/01/09 at 3:50 PM, a review of Patient # 6's medical record revealed no documented evidence the nursing staff initiated a Pressure Ulcer Wound Care Protocol or Pressure Ulcer Monitoring Tool for the patient.							
	Severity: 2 Sci	one: 1					

STATE FORM

Complaint #NV00018985

S 322 NAC 449.3628 Protection of Patients

2. The governing body shall develop and carry

S 322

05/01/2009

### Bureau of Health Care Quality & Compliance

STATEMENT	OF	DEFICI	ENCIES
AND PLAN OF	E Co	DRREC	TION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	COMPLETED

NVS641HOS

B. WING \_\_ STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

NAME OF PROVIDER OR SUPPLIER		SIKEELAD	DRESS, CITY,	STATE, ZIP CODE	
		ST FLAMING AS, NV 891			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 322	Continued From page 21 out policies and procedures that preven prohibit neglect and misappropriation of personal property of a patient.	procedures that prevent and and misappropriation of the		Tag S 322 The identified patient had been discharged prior to the survey and it is not possible to address this particular patient.	
	This Regulation is not met as evidence Based on record review and document if facility failed to carry out policies and proto prevent the neglect of personnel propatient. (Patient #3)  Findings include:  On 04/21/08 a report from the Division of Services indicated Patient #3 was dischable from the facility on 04/18/08, with clothing or belongings and wrapped only blanket.	d review and document review the carry out policies and procedures eglect of personnel property of a #3)  e:  eport from the Division of Aging ed Patient #3 was discharged facility on 04/18/08, with no		All patients admitted to the facility have the potential to be affected by this practice.  The policy and procedure has been reviewed, no revisions were required. The Director/Manager of the unit involved with this individual patient has reviewed the policies and procedures related to the documentation and care of patient's personal effects and valuables with her staff. Additionally this information was reviewed by Directors/Managers of all clinical and ancillary departments	
	Emergency Room Nursing record dated 04/17/08, indicated the patient was brown emergency room by ambulance from he patient was disrobed at 6:45 AM and plagown.  A facility Exit Care Patient Information for 04/18/08 at 7:30 PM, revealed the only dinstruction documented on the form was patient to follow-up with her primary care physician in 1 week.  A Nursing Note dated 04/18/08 at 7:30 Findicated the patient was discharged hor	ght to the me. The aced in a corm dated discharge for the		The facility policy states that a Belongings Inventory must be completed at time of admission. Patients are encouraged to send home valuables with family members or have the valuables locked in the security safe.  The facility has developed a Hands Off Communication tool, "The Ticket to Ride". The tool is for all patients admitted via the Emergency Department and transferred within the facility and one of the issues addressed is belongings.  Individuals responsible:  Director/Manager of	
	medi coach via a stretcher.  On 04/30/09 at 8:00 AM, a review of the	retcher.		Medical/Surgical Units, Director/Manager of Critical Care, Director of Ancillary Departments	

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record indicated there was no documentation of a

completed patient belongings form filled out by

Date of Completion: June 30, 2009



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S COMPLI		
NVS641HOS			B. WING		05/01/2009		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE	03/0	1/2009
DESERT	SPRINGS HOSPITAL	•	2075 EAS	T FLAMING AS, NV 891	GO ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
\$ 322	Continued From pa	ge 22		S 322			
	the facility when the patient was admitted and no documentation of belongings returned to the patient upon discharge.  On 05/01/09 at 8:30 AM, the Performance Improvement Manager reviewed Patient #3's medical record and confirmed there was no documented evidence of a patients belonging form. The Performance Improvement Manager indicated the nursing staff failed to follow the facility's Personal Effects and Valuables Policy by not documenting the patient's valuables and personal effects on the Patient Personal Effects and Valuables form upon admission to the facility.  A facility Nurses Discharge Notes and Instruction Policy dated 05/07, indicated under Procedure: Patient Instructions should include:  a. A completed medication reconciliation. b. How to meet the needs for physical, emotional pain management. c. Available community resources. d. The nurse will document what the physician ordered for follow-up care. e. The nurse will instruct the patient on activity level, diet, equipment needed f. The nurse will check those items instructed to the patient. g. The nurse will document whether the patient verbalizes understanding of the instructions by		S 322				
	checking the yes or no box.  h. The nurse will document the valuables returned and personal belongings by checking the yes or no box.						
	The facility's Safe Care of Patient's Personal Effects and Valuables Policy dated 09/08, included the following:						

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STATEMENT	OF	DEFICI	ENCIES
AND PLAN OF	CC	RREC	TION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVS641HOS

A. BUILDING

B. WING

05/01/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### **DESERT SPRINGS HOSPITAL**

2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

DESERT				EGAS, NV 89119				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED I REGULATORY OR LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
S 322	"The Patient Personal Effects and Val Checklist must be filled out upon adm by nursing personnel, and signed by to rnext of kin. The Patient Personal Ei Valuables Checklist filled out in the EI (emergency department) will be kept i patient's medical record, filed under Miscellaneous. Patient valuables and shall be returned only to the patient."  Severity: 2 Scope: 1  Complaint #NV00018051	ission he patient ffects and ) n the	S 322					
SS=D	1. A hospital shall have written policies concerning the qualifications, responsibilities and conditions of employment for each type of hospital personnel, including the licensure and certification of each employee when required by law.  This Regulation is not met as evidenced by: Based on interview and document review the facility failed to ensure policies concerning employment, licensure and certification of a physician were followed when required by law.  Findings include:  A letter from the Nevada State Board of Medical Examiners dated 04/13/09 indicated Physician #1's privileges were suspended at the facility on 02/06/09. The Board of Medical Examiners received notice of the physician's suspension from the facility on 04/01/09.  NRS 630.307 (2) included any hospital, clinic or other medical facility licensed in this State, or		S 335	Tag S 335 The facility failed to notify the Nevada Board of Medical Examiner within the 30 day timeframe dictated by Nevada law. There was confusion regarding when the time period for reporting started, this physician had his privileges re-instated and then resigned while still under investigation, so staff was unsure of which date started the timeline for reporting. The Medical Staff Manager and staff were counseled and have been re-educated on the Nevada Statutes and understand how and when to report any disciplinary action taken against a physician.  Individual Responsible: Medical Staff Manager, Performance Improvement Manager, Risk Manager  Date Completed: May 1, 2009				
d-6-::		tate, or						

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PRINTED: 06/05/2009 FORM APPROVED

05/01/2009

Bureau of Health Care Quality & Compliance

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING	COMPLETED

NVS641HOS

B. WING \_\_\_\_\_
STREET ADDRESS, CITY, STATE, ZIP CODE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 335	change in a physician's privileges to pra-	ctice	S 335		
	change in a physician's privileges to practice medicine while the physician is under investigation and the outcome of any disciplinary action taken by the facility against the physician concerning the care of a patient or the competency of the physician within 30 days after the change in privileges is made or disciplinary action is taken.				
	On 04/30/09 at 10:00 AM, the Manager Medical Staff Services indicated the faci NRS 630.307 (2) as policy in regards to a suspension of a physician's privilege to at the facility. The Manager of Medical Services indicated Physician #1's privilege practice at the facility was suspended or 02/06/09 due to disruptive conduct that distraction to a surgeon and clinical and supportive staff which represented a prodanger to a patient. Physician #1 met wifacility's Medical Executive Committee of 02/18/09, and the Medical Executive Coagreed to lift the physician's summary support the physician's agreement to abide facility's Privilege Retention Conditions wincluded the following:	lity used reporting or practice staff ges to a caused a sabability of the the numittee uspension by the			
	a. Physician report to the Nevada Physic Health Program for issues related to any management and that he must comply veconditions imposed by the NPHP (Nevada Physicians Health Program) based upon outcome of an evaluation; comply with the Hospitals Bylaws.  b. Conduct himself in a professional management and from any form or type of a which is indicative of disruptive behavior but not limited to, unprofessional interactive verbal or physical displays of anger or last sensitivity for patient and staff.	ger vith the da the ne nner conduct including tions and			

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STATE FORM

M5KS11

If continuation sheet 25 of 27

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING NVS641HOS 05/01/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2075 EAST FLAMINGO ROAD **DESERT SPRINGS HOSPITAL** LAS VEGAS, NV 89119 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 335 Continued From page 25 S 335 d. Comply with the terms and conditions of the Bylaws or MEC; (Medical Executive Committee) e. Comply with the recommendations of the NPHP. The Manager of Medical Staff Services indicated Physician #1 agreed to the Privilege Retention Conditions and the summary suspension was lifted and his medical staff membership and clinical privileges were reinstated effective 03/03/09. Physician #1 resigned from the facility on 03/26/09. The Manager of the Medical Staff Office acknowledged there was a delay in sending a notification of suspension of privileges for Physician #1 to the Board of Medical Examiners and confirmed the letter was sent on 03/26/09 which was 48 days after his suspension. The manager acknowledged the notification of suspension should have been made within 30 days per the facility's policy and NRS 630.307 (2). A copy of a Special Notice of Summary Suspension dated 06/06/09, and addressed to Physician #1 indicated the Medical Executive Board of the facility had summarily suspended the physician's medical staff membership effective 02/06/09. A copy of a Proposal for Termination of Summary Suspension dated 02/19/09, and addressed to Physician #1 indicated the Medical Executive Board, after meeting and reviewing the issues surrounding the suspension had recommended the summary suspension be terminated provided the physician complied with conditions of a Privilege Retention Agreement. A copy of a letter sent by the facility to the State Board of Medical Examiners dated 03/26/09,

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indicated Physician #1's privileges were

STATEMENT	OF DEFICIENCIES
AND PLAN OF	F CORRECTION

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NVS641HOS

B. WING

05/01/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DESERT SPRINGS HOSPITAL 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

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S 335	Continued From page 26 summarily suspended at the facility on 02/06/09 for patient safety issues and the suspension was subsequently lifted on 03/03/09.  Severity: 2 Scope: 1  Complaint #NV00021612	S 335		

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